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MEDICAID

QUESTIONS AND ANSWERS

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Part I INTRODUCTION

1-1 Who is eligible for Medicaid?

Persons who are aged, blind, or disabled, or members of families with dependent children can qualify for Medicaid if they meet their State's income and resource limits.

> Age, blindness and disability criteria for Medicaid are generally the same as the definitions used by the Social Security Administration to determine eligibility for Supplemental Security Income (SSI) cash assistance benefits, although a few States have more restrictive definitions for Medicaid.
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> For Medicaid purposes, "families with dependent children" are families that have one parent dead, absent or incapacitated, or in some States, an unemployed or underemployed father.

At State option, certain other groups may be included, such as needy persons under age 21.

The types of people eligible for Medicaid and the income and resource limits they must meet vary widely from State to State; detailed information on eligibility can be found in Parts 2 and 3.

1-2 What is meant by categorically needy and medically needy?

Categorically needy and medically needy are terms used to define Medicaid recipients according to the income and resource levels they meet:

> Categorically needy families and children are those who qualify for Medicaid because they can meet the income and resource limits for receipt of cash assistance available under the Aid to Families with Dependent Children (AFDC) program. Categorically needy aged, blind or disabled persons are those who meet: (a) in most States, the income and resource limits for receipt of Supplemental Security Income (SSI) benefits or State supplementary payments; or, (b) in some States, more restrictive income and resource limits than those applied by the SSI program.
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> The medically needy are persons whose income and resources are too high to qualify as categorically needy but who cannot afford to pay their medical bills. Their resources must be within State limits and the amount of their incurred medical expenses must equal or exceed the amount of income they have above the State income level.

Both categorically and medically needy persons must first qualify under one of the coverage groups included in the State's Medicaid program (See Part 2).

1-3 Is everyone who is poor enough to qualify for cash assistance also eligible for Medicaid?

Everyone who receives cash assistance available under the State-Federal programs of Aid to Families with Dependent Children (AFDC) is automatically eligible for Medicaid. In most States, all aged, blind or disabled persons who receive Supplemental Security Income (SSI) cash benefits are automatically eligible for Medicaid. States which do not cover all SSI receipients must allow all persons who qualify as aged, blind or disabled to deduct their medical expenses from their income before measuring their financial eligibility.

Most States make additional cash assistance payments to some groups of aged, blind and disabled. At State option, persons who receive such State supplementary payments can be eligible for Medicaid if the payments meet certain Federal conditions.

Persons who are eligible for Medicaid because they can meet the income and resources requirements for cash assistance are called the categorically needy. Many States make "general assistance" payments to needy persons who cannot qualify for SSI benefits or AFDC payments. The cost of any medical assistance provided to such persons must be totally funded by the State since persons who do not qualify under one of the coverage groups in the State Medicaid plan are not eligible for Medicaid benefits under title XIX.

1-4 What about people who are not poor enough to qualify as categorically needy but who cannot afford to pay their medical bills?

They are called the medically needy. About half the States extend Medicaid coverage to this group. Only those persons who can qualify under one of the coverage groups included in the State Medicaid plan can become eligible as medically needy.

Each State with a medically needy program sets income and resource levels, adjusted by family size, for determining financial eligibility of all such persons. Those who meet the resource limits and whose income, after deduction of their incurred medical expenses, is at or below the State's income level, are eligible.

Part 2 ELIGIBILITY GROUPS - Who Can Receive Medicaid Benefits

2-1 What groups of families and children must every State include in its Medicaid program?

These groups are entitled to Medicaid as categorically needy:

a. Everyone receiving cash assistance under the State's AFDC program.

b. Everyone who would be eligible for AFDC except for an eligibility condition specifically prohibited by title XIX, including everyone under age 21 who, except for age or school attendance requirements, could qualify for AFDC cash assistance.

c. All families whose AFDC cash assistance is terminated because of increased income from or hours of employment, if they had received AFDC for at least 3 of the 6 preceding months. As long as a member of the family is employed, Medicaid benefits continue for four months beginning with the month they became ineligible for AFDC.

d. Everyone who was eligible for AFDC payments in August 1972 and who would now be eligible to receive AFDC payments if the amount of the 1972 twenty percent Social Security increase he received were deducted from income.

2-2 What groups of aged, blind or disabled persons must every State include in its Medicaid program?

Every State must include these groups as categorically needy:

a. Either:

1. All persons receiving SSI cash benefits, including those who would be eligible for SSI except for an eligibility condition specifically prohibited by title XIX (2-6) and, everyone who was eligible for cash assistance in August 1972 under title I, X, XIV or XVI of the Social Security Act and who would now be eligible for SSI benefits or State supplementary payments if the amount of the 1972 twenty percent Social Security increase he received were deducted from income; or,

2. All persons who, after their incurred medical expenses are deducted from their income, meet State-established Medicaid eligibility conditions more restrictive than those required for receipt of SSI benefits. Eligibility conditions cannot be more restrictive than those in effect in the State in January 1972.

b. All persons who receive "mandatory supplement" payments, which States must make to persons whose income under the SSI program is less than it was when they were receiving cash assistance in December 1973 under State-Federal programs of aid to the aged, blind and disabled.

c. Any person who was eligible for Medicaid in December 1973 as an "essential spouse" of a cash assistance recipient, if the former recipient continues to meet the December 1973 conditions for cash assistance eligibility and the spouse continues to meet the conditions of eligibility as an "essential spouse."*

d. All persons who were eligible for Medicaid in December 1973 who would then have been eligible for cash assistance except that they were inpatients or residents in medical institutions, as long as they continue to receive needed care in the institution and continue to meet the December 1973 eligibility conditions.*

e. All persons who meet the categorically needy income and resource limits for the blind and disabled but who cannot meet the definition of blindness or disability, if they were eligible for Medicaid as blind or disabled in December 1973 and they continue to meet all the December 1973 conditions of eligibility for Medicaid.*

2-3 How can a State expand its Medicaid program beyond the required groups listed above?

To increase the kinds of persons who can be eligible, the State may add any of the optional categorically needy groups listed in 2-4. To extend Medicaid to persons who cannot qualify as categorically needy because their income and resources are too high, the State may establish a medically needy program.

2-4 What are the optional groups of categorically needy?

a. Persons who would be eligible for AFDC payments, SSI benefits, or certain State supplementary payments, but who have not applied for cash assistance.

b. Persons in medical institutions whose income is sufficient for their needs while in the institution, but who would be eligible for cash assistance if they were living in the community.

* These are groups "grandfathered-in" to continued Medicaid coverage which would not have been available to them with implementation of the SSI programs in January 1974.

c. Aged, blind or disabled persons who receive an approved State supplementary payment, providing their gross income does not exceed 300% of the SSI benefit level. To include this group, the supplementary payment must be paid in cash on a regular basis to a reasonable group of persons who, except for income, would be eligible for SSI benefits.

d. Drug addicts and alcoholics who could qualify for Medicaid as SSI recipients except that they do not receive SSI benefits because they refuse to accept required treatment.

e. Persons who would be eligible for AFDC payments if the State AFDC program were as broad as the Social Security Act allows, such as persons who would be eligible for AFDC payments if the State AFDC program included unborn children or families with unemployed fathers.

f. All persons under age 21 who meet the AFDC income and resource limits but who do not meet the definition of a dependent child under the AFDC program, such as emancipated children or children of 2-parent homes where neither parent is absent, incapacitated or unemployed. States may limit coverage to reasonable groups such as children in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities.

g. Certain relatives who are caring for children under age 21 who would be eligible for AFDC payments except for AFDC age or school attendance requirements.

h. Persons who would be eligible for AFDC payments if they did not receive child care services through the agency but had to pay child care costs out of their earnings.

States may add other groups, subject to approval by the Secretary.

2-5 <u>If a State has a medically needy program, what groups can be eligible</u>?

The medically needy program must include all of the same groups that are covered in the State as categorically needy, except for persons whose Medicaid benefits are continued for four months after loss of AFDC eligibility, and persons eligible as categorically needy because they are receiving mandatory supplement payments, or because they were "grandfathered-in" to continued Medicaid coverage as an essential spouse or as a patient in a medical institution.

Persons who can meet the medically needy income and resource limits but not the definitions of blindness or disability must be included if they were eligible as medically needy blind or disabled persons in December 1973 and they continue to meet the December 1973 conditions of eligibility.

2-6 What eligibility conditions are prohibited by title XIX?

No State Medicaid program may impose:

a. an age requirement of more than 65 years;

b. an age or school attendance requirement that would preclude coverage of anyone under 21 who otherwise qualifies as a dependent child under AFDC;

c. any durational State residency requirement; or

d. any citizenship requirement which excludes any U.S. citizen.

2-7 Must a person have lived in the State any specified length of time to qualify for Medicaid?

No. A State Medicaid program cannot require that a person shall have lived in the State for a specified period of time to qualify for Medicaid. It must include everyone who is a resident of the State--that is, everyone who is living in the State and is not merely a transient or a visitor from another State--and is otherwise eligible. Temporary absences do not interrupt continuity of residence.

A State may, if it wishes, include nonresidents.

2-8 Can a migratory farm worker or other person who customarily travels from State to State qualify for Medicaid?

Although a few States extend Medicaid to anyone who meets the eligibility group requirements and income and resource limits, most States require that eligible persons be residents of the State to qualify for Medicaid. Persons who travel often should apply for Medicaid in the State where they usually live and where they intend to return when the purpose of the temporary absence is accomplished.

2-9 Can a person who is not a citizen of the United States qualify for Medicaid?

State Medicaid programs must include any otherwise eligible person who is a resident of the U.S. and is either (a) a citizen or (b) an alien lawfully admitted for permanent residence or who is permanently residing in the U.S. under color of law (including those present under sections 203(a)(7) or 212(d)(5) of the Immigration and Nationality Act).

2-10 Can eligibility be established for a deceased person?

Up to three months retroactive eligibility may be granted for a deceased person who could have qualified for Medicaid at the time during that period when he or she received services covered by the State's program (4-5, 4-8).

2-11 Can an eligible person's ineligible husband or wife qualify for Medicaid?

A Medicaid recipient's husband or wife who does not qualify under one of the coverage groups included in the State's plan is not entitled to Medicaid benefits unless he or she was "grandfathered-in" to continued Medicaid coverage as an "essential spouse" of someone who received cash assistance under the old programs in December 1973 (2-2c).

2-12 Can persons living in public institutions qualify for Medicaid?

Federal funds are not available to States for medical payments made on behalf of persons who are residents in any public institutions except as inpatients of a public institution certified under title XIX as a medical facility. Persons who are committed under the penal system to a public institution are not entitled to Medicaid benefits even though they may be receiving care in a public medical facility.

2-13 Can an otherwise eligible person who has some health insurance qualify for Medicaid?

Yes. States must make sure, however, that other health insurance benefits which the individual has are used before payment is made under Medicaid. If a bill has already been paid by Medicaid and it is later found that insurance coverage was available, States will take steps to secure reimbursement.

Through "Buy-In" agreements with the Social Security Administration, State Medicaid programs can pay the Medicare Part B (Supplementary Medical Insurance, SMI) premium for persons eligible for both Medicare and Medicaid benefits. Medicare then pays part of the medical care costs that would otherwise have to be met with Medicaid funds.

2-14 Can a self-employed person qualify for Medicaid?

Whether a person is self-employed or works for an employer has no bearing on his Medicaid eligibility. A person can receive Medicaid services if he meets State eligibility-group requirements and financial needs standards.

Part 3: FINANCIAL ELIGIBILITY - Income and Resource Limits

3-1 How much income and resources can eligible families, children, and young people under 21 have and still qualify for Medicaid?

In all States, those whose income and resources are within the levels set by the State for receipt of AFDC payments can qualify as categorically needy. Income levels reflect the basic and special needs recognized by each State as essential to families and children. Resource levels are also set by the State; usually the home and auto of reasonable value, certain income-producing peoperty, and limited amounts of other real and personal property are not counted.

In States which cover the medically needy, eligible families and children whose income and resources are above the AFDC levels can qualify if their medical expenses equal or exceed the income they have above the medically needy level, and if their resources are within the medically needy limits (3-,4 5).

3-2 How much income and resources can eligible aged, blind or disabled persons have and still qualify for Medicaid?

In most States, those who meet the income and resource levels set by the Social Security Administration for receipt of SSI benefits also qualify for Medicaid as categorically needy. At State option, the categorically needy income level can be higher for aged, blind or disabled persons who qualify for State supplementary payments; the resource limits will be the same as for SSI benefits (2-4c).

In States which have more restrictive eligibility conditions for Medicaid (2-2a), the income and/or resource levels for the categorically needy may be lower than those for SSI benefits. In those States, however, the medical expenses of an eligible aged, blind or disabled person, as well as any SSI benefit or State supplementary payment he receives, are deducted from income before measuring financial eligibility. For example, if the State's monthly income level were $110, an otherwise eligible person with $160 monthly income could qualify after he had incurred at least $50 in medical expenses.

In States with medically needy programs, eligible aged, blind or disabled persons whose income and resources are above the categorically needy levels can qualify if their medical expenses equal or exceed the income they have above the medically needy level, and if their resources are within the medically needy limits (3- 4, 5).

3-3 Are all income and resources counted?

Only income and resources which are currently available to the applicant are counted. Generally, "available income" which is counted

in the eligibility determination will include income of the applicant's spouse or parents (if he/she is under age 21 or blind or disabled), if they are living in the same household.

In addition to excluding the resources described above (3-1,2), certain income is not counted in determining financial eligibility for Medicaid:

For categorically and medically needy families and children, all States must disregard income that is not counted in determining financial eligibility for AFDC payments. The basic AFDC disregards include earnings of a child under age 14 or a student who is not employed full-time, expenses of employment, certain loans, grants and scholarships, home produce for family consumption, and the value of food stamps and USDA donated foods. The amounts of those and other disregards vary among the States.

For aged, blind or disabled persons in States which cover all SSI recipients as categorically needy, income not counted in determining financial eligibility for SSI benefits must also be disregarded for Medicaid. The basic SSI disregards are: the first $20 per month of any income; the first $65 per month of earned income and one-half the remainder, plus additional amounts necessary to achieve a plan of self-support (for the blind or disabled) and expenses of employment (for the blind); up to $1620 per year of earnings of an unmarried student under age 22; property or food tax refunds; State assistance payments based on need; educational grants or scholarships; home produce for family consumption; certain child support of foster care payments; and a limited amount of income received too infrequently to be counted. At State option, additional disregards may be allowed for persons eligible as categorically needy because they receive State supplementary payments.

More limited income disregards may be allowed to aged, blind and disabled persons in States which impose more restrictive eligibility conditions for Medicaid (2-2a.), except that the amount of the individual's incurred medical expenses and any SSI benefit or State supplementary payment he receives must be deducted from his income.

Medically needy aged, blind or disabled persons are entitled to the highest disregards which the State allows for categorically needy aged, blind or disabled persons.

After all the appropriate disregards have been subtracted, the net or " countable" income a person or family has is measured against the State's categorically or medically needy income level to determine financial eligibility.

Income from OASDI or other retirement or pension benefits is counted as unearned income of the individual (except that the amount of the twenty percent OASDI increase received in August 1972 will be deducted for certain individuals (2-1d., 2-2a.)).

3-4 How do States set income and resource levels for the medically needy?

A single income level, adjusted by family size, is used to determine eligibility of all medically needy persons, whether they are aged, blind or disabled, members of a family with dependent children, or, in some States, an individual under age 21. For Federal matching in State Medicaid payments, the income level must be within 133 1/3 percent of the State's AFDC cash payment level for a family of the same size. Within this limit, medically needy levels must be at the highest of the categorically needy income levels used by the State for each family size.

All medically needy persons in a State must meet the same resource levels, which are adjusted by family size. The resource levels must be at least the highest the State allows for a categorically needy individual or family of the same size.

3-5 How is financial eligibility of a medically needy person or family determined?

After all the appropriate disregards have been subtracted (3- 3), income is measured against the State's medically needy income level for a person or family of the same size. Those whose countable income is below the medically needy level are automatically eligible. Those with countable income above the medically needy level must "spend-down" to establish eligibility: they must incur medical expenses in an amount equal to their excess income. For example, if the State determines eligibility on a quarterly basis, and the income level for a family of four is $1200, an eligible family with $1400 in quarterly income must incur at least $200 in medical expenses to qualify. Those espenses are their liability; any additional medical services included in the State's program which they need during the rest of the quarter will be paid by Medicaid.

Medical expenses which can be counted toward the "spend-down" liability include the costs of medical insurance premiums and any medical or remedial care recognized under State law, providing those costs are not reimbursible by a third party such as under a health insurance policy held by the applicant. The "spend-down" liability may be met with incurred medical costs; States may not require that the applicant actually pay his medical bills as a condition of eligibility.

3-6 How are the income and resources of someone in a medical institution counted?

In nearly all States, the income and resource levels used to determine eligibility of non-institutionalized categorically or medically needy persons in the same eligibility group (aged, blind, disabled, members of families with dependent children, or individuals under age 21) are also used to measure financial eligibility of persons in medical institutions or intermediate care facilities. Those States can set a higher income level to determine categorically needy eligibility of

institutionalized aged, blind or disabled persons, but it must be within 300 percent of the SSI benefit level.

In two or three States, eligible persons in medical institutions or intermediate care facilities must be receiving AFDC or SSI cash payments to qualify as categorically needy; most institutionalized persons in those States can qualify as medically needy, by deducting their incurred medical expenses from income.

Since Medicaid pays for most of the institutionalized person's basic needs (shelter, food, etc.), all the income he has above an amount protected for his personal and incidental needs must be applied toward the cost of his medical care. Personal needs allowances are set by the State. At least $25 per month must be protected for institutionalized aged, blind or disabled persons; lesser amounts for others (eg., children) must be based on a reasonable differential in need. Higher amounts must be protected to maintain a home outside the institution for the individual's spouse or dependents. At State option, a higher amount may be protected to maintain a home for someone likely to be in the institution less than 6 months.

3-7 Can a lien be placed on a home or other property because of the medical assistance provided to a family or individual?

No liens or encumbrances of any kind, because of medical assistance paid on his behalf, can be imposed on an individual's real or personal property before his death, or at any time if he was under age 65 when he received the assistance. An exception may be made if a court decides that benefits have been incorrectly paid.

Adjustments or recovery for medical assistance correctly paid can be sought only from the estate of an individual who was aged 65 or older when he received such assistance, and then only (1) after the death of his surviving spouse, if any, and (2) when he has no surviving child who is under age 21 or is blind or disabled.

Part 4: APPLICATION AND ADMINISTRATION

4-1 Who may apply for Medicaid?

Anyone who wishes to do so may apply for Medicaid.

4-2 How are a person's rights protected in the eligibility determination process?

In determining eligibility, States must respect the rights of individuals under the United States Constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, and all other relevant provisions of Federal and State laws. The procedures must meet Federal requirements for prompt action on applications and fair treatment for individuals.

4-3 Must an eligible person accept medical care even if it is contrary to his religious beliefs?

A State may not compel anyone to undergo medical screening, diagnosis, or treatment that is contrary to his religious beliefs. However, anyone applying for Medicaid on the basis of blindness or disability must submit to a medical examination to ascertain whether the blindness or disability meets Federal and State eligibility group definitions.

4-4 Where should a person apply for Medicaid?

The agency or agencies taking applications will vary from State to State. In some States, everyone will apply at the local public health or welfare agency; in others, aged, blind, and disabled individuals may apply through the local Social Security Office.

Persons unsure of where to apply for medical assistance should contact the local public welfare agency.

4-5 Can application be made by phone or letter?

A signed, written application on a form prescribed by the State must be filed by every applicant or his authorized representative, or, if he is incompetent, incapacitated, or deceased, by someone acting in his behalf. In some States, an aged, blind or disabled person's application for SSI benefits can also be used as his application for Medicaid.

4-6 How much time does the State have to process applications for medical assistance?

Decisions on applications must be made within 60 days for persons applying as disabled and within 45 days for all other applicants. These time standards cover the time from the date when the written application is filed to the date when notice of eligibility or denial of eligibility is mailed to the applicant. Time limits may not be extended except in unusual circumstances.

4-7 Is medical care available while the application is being processed?

Although payment for the full range of services included in the State's program will not be authorized until eligibility is determined, States must assist all applicants and recipients in obtaining medical care in emergencies on a 24-hour basis, 7 days a week.

4-8 When does a person's eligibility begin?

A person's Medicaid eligibility begins three months prior to the date of application if he could have qualified for Medicaid on the dates within that period when he received services covered by the State program. At State option, eligibility can begin as early as the first day of the third prior month if he was eligible at any time in that month, except that in States where an application for SSI benefits also constitutes an application for Medicaid, the SSI/Medicaid application is always effective with the first day of the month in which it is filed.

4-9 When does eligibility end?

Generally, eligibility continues until the individual is found to be ineligible; all recipients must report any change in circumstances which may affect their eligibiltiy.

If a recipient has timely requested a hearing on a question other than State or Federal policy, medical assistance will continue until the case is resolved.

As long as a member of the family is employed, families who become ineligible for AFDC benefits because of increased income from or hours of employment will continue to be eligible for Medicaid for four months, beginning with the month they became ineligible for AFDC.

At State option, eligibility can continue until the end of the month if the individual was eligible at any time in the month. Also, State may continue a person's eligibility for a temporary period while he is overcoming a condition of eligibility such as blindness, disability, continued absence or incapacity of a parent, or unemployment of a father; for persons not receiving cash assistance, the temporary period cannot exceed two months beyond the month they became ineligible.

Medicaid eligibility of an SSI recipient can continue through the second month after the State has received notice from SSA that his SSI benefits have been discontinued, so that the State will have time to review his Medicaid eligibility and notify the recipient.

4-10 How often is eligibility redetermined?

Eligibility will be reviewed periodically at intervals set by the State, but at least every 12 months. Redeterminations will also be scheduled when the agency knows about anticipated changes in the individual's situation and within 30 days after changes have been reported.

4-11 What information is available to States from the Social Security Administration (SSA)?

Through the SSA-State Data Exchange System (SDX), SSA can supply States with updated lists of persons eligible for SSI benefits and State supplementary payments which are administered by SSA, including persons whose cash benefits have been suspended or discontinued SSA's "SDX Handbook" describes the services which SSA can provide to the States and the data available through the SDX system.

4-12 What services can SSA perform for the States?

States may enter into agreements with the Secretary for SSA to administer State mandatory supplement payments, and State optional supplement payments which meet certain conditions (the supplement must be paid in cash, on a regular basis, to a reasonable group of people who, except for income, would be eligible for SSI benefits; i.e., except for income and income disregards, all the eligibility conditions for the supplement must be the same as for SSI benefits).

States which extend Medicaid to all SSI recipients may also enter into agreements for SSA to determine Medicaid eligibility of persons receiving SSI benefits, and those receiving mandatory State supplement payments which are administered by SSA. Where the State covers all persons receiving optional supplement payments as categorically needy (2-4c), SSA will determine their Medicaid eligibility if the supplementary payment is also administered by SSA. For persons whose Medicaid eligibility is determined by SSA, the application for SSI benefits will also be used as the individual's application for Medicaid, unless he does not want to apply for Medicaid.

4-13 What share of the administrative costs must be met by the State, under an agreement for SSA to provide SDX listings of cash eligibles or to determinie Medicaid eligibility of cash recipients?

SSA will pay one-half the costs necessary to carry out the agreement (which are in addition to SSA's costs of maintaining records of

eligibles or determining eligibility for cash assistance). Since the title XIX program will match the State's share at fifty percent, the State pays only 25 percent of the administrative costs of obtaining eligibility data from SSA or of determining eligibility of persons covered under the agreement.

4-14 What are the responsibilities of a State which has entered into an agreement for SSA to determine Medicaid eligibility of aged, blind and disabled cash assistance recipients?

In addition to determining Medicaid eligibility of all applicants not covered under the agreement, the State remains responsible for:

a. Assuring emergency medical care is available while applications are being processed.
b. Outstationing eligibility workers at providers of medical care (eg., hospitals and nursing homes).
c. Administering any cost-sharing requirements imposed by the program on Medicaid recipients.
d. Issuing Medicaid identification cards and notifying applicants and recipients of eligibility decisions.
e. Determining retroactive eligibility for Medicaid.

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